MDR Tracking Number: M5-04-2345-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 03-29-04.

The IRO reviewed level II office visits, therapeutic exercises, muscle testing and therapeutic activities rendered from 01-06-04 through 01-28-04 that were denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee. The respondent raised no other reasons for denying reimbursement for the above listed services.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 07-13-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

Review of CPT code 99212 on dates of service 01-02-04, 01-08-04 and 01-14-04 revealed neither the requestor nor the respondent submitted copies of EOB's. Per Rule 133.308(f)(2)(3) the requestor provided proof of resubmission or convincing evidence of carrier receipt of reconsideration via certified mail. Reimbursement is per the Medicare program reimbursement methodology for dates of service after August 1, 2003 per Commission Rule 134.202(c). Reimbursement in the amount of $146.97 ($39.19 X 125% = $48.99 X 3 DOS) is the MAR. However, the requestor billed $47.23 per date of service. Reimbursement in the amount of $141.69 ($47.23 X 3 DOS) is recommended.

Review of CPT code 97110 date of service 01-02-04 and 01-08-04 revealed neither the requestor nor the respondent submitted copies of EOB's. Per Rule 133.308(f)(2)(3) the requestor provided proof of resubmission or convincing evidence of carrier receipt of reconsideration via certified mail. Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one". Therefore, consistent with the general obligation set forth in Section

413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation. The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

Review of CPT code 95999-WP date of service 01-09-04 revealed neither the requestor nor the respondent submitted copies of EOB's. Per Rule 133.308(f)(2)(3) the requestor provided proof of resubmission or convincing evidence of carrier receipt of reconsideration via certified mail. Reimbursement is recommended in the amount of $384.00.

Review of CPT code 95851 (2 units) date of service 01-14-04 revealed neither the requestor nor the respondent submitted copies of EOB's. Per Rule 133.308(f)(2)(3) the requestor provided proof of resubmission or convincing evidence of carrier receipt of reconsideration via certified mail. Reimbursement is per the Medicare program reimbursement methodology for dates of service after August 1, 2003 per Commission Rule 134.202(c). Reimbursement in the amount of $52.80 ($21.12 X 125% = $26.40 X 2 units) is recommended.

Review of CPT code 97530 (4 units) date of service 01-14-04 revealed neither the requestor nor the respondent submitted copies of EOB's. Per Rule 133.308(f)(2)(3) the requestor provided proof of resubmission or convincing evidence of carrier receipt of reconsideration via certified mail. Reimbursement is per the Medicare program reimbursement methodology for dates of service after August 1, 2003 per Commission Rule 134.202(c). Reimbursement in the amount of $150.32 ($30.06 X 125% = $37.58 X 4 units) is the MAR. However, the requestor billed $145.92 therefore reimbursement in the amount of $145.92 is recommended.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202(c) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 01-02-04, 01-08-04, 01-09-04 and 01-14-04 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Findings and Decision and Order are hereby issued this 29th day of October 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

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Austin, Texas 78758

Ph. 512/248-9020 **Fax 512/491-5145**
IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

June 10, 2004

Re: IRO Case # M5-04-2345

Texas Worker's Compensation Commission:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is a Doctor of Chiropractic who is licensed by the State of Texas, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to Envoy for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the Envoy reviewer who reviewed this case, based on the medical records provided, is as follows:

<u>Medical Information Reviewed</u>

1. Table of disputed service 1/6/04 – 1/28/04
2. Explanation of benefits
3. Review 11/21/03
4. TWCC 69 1/7/04
5. TWCC work status repots

6. Report 1/7/03
7. TWCC change of treating doctor 10/22/03
8. Report 9/10/03
9. M.D. progress notes
10. M.D. consultation notes and operative report
11. Treating D.C. treatment notes
12. Sensory nerve conduction study report 1/9/04
13. FEC report 12/17/03
14. Report 12/4/04

History

The patient injured her left thumb in ___ when an air cylinder crushed it. Surgery was performed and OT was recommended. The patient then sought the care of the treating D.C. for post operative therapy. Several weeks of post-operative therapy took place prior to the dates in dispute.

Requested Service(s)

Level II office visits, therapeutic exercises, muscle testing, therapeutic activities 1/6/04 – 1/28/04

Decision

I agree with the carrier's decision to deny the requested services.

Rationale

The patient received a around five weeks of conservative therapy prior to the dates in dispute with good results. She was placed at MMI on 1/7/04. The records provided by the treating D.C. showed that the patient responded very well to treatment prior to MMI. Five weeks of intensive post-operative therapy for a fracture of the distal phalanx of the thumb is reasonable. The documentation provided for this review indicates that during the dates in dispute the patient showed no further improvement either objectively or subjectively. OTC medication and a home-based exercise program would have been appropriate by the time of the dates in dispute. Further treatment and testing was inappropriate and over utilized for a relatively minor injury.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.